



2021 IHCP Works
Claims 101: CMS-1500 & UB-04 Annual Seminar

A photograph of a young child with curly hair, wearing a blue and grey striped long-sleeved shirt and tan cargo pants. The child is standing between the legs of an adult wearing blue jeans. The adult's hands are resting on the child's shoulders. The background is a solid purple color.

Agenda

- **About CareSource**
- **Member Eligibility and Credentialing**
- **Claim Submission**
- **Provider Payment Processing: ECHO Health, Payment Options**
- **Claim Concerns: Disputes/Appeals**
- **Top Denial Reasons: Top 8 Reasons, Resolution, Code Sets**
- **Important Updates/Reminders**
- **CareSource Health Partner Contacts**

About CareSource

Our **MISSION**

To make a lasting difference in our members' lives by improving their health and well-being.

OUR PLEDGE:

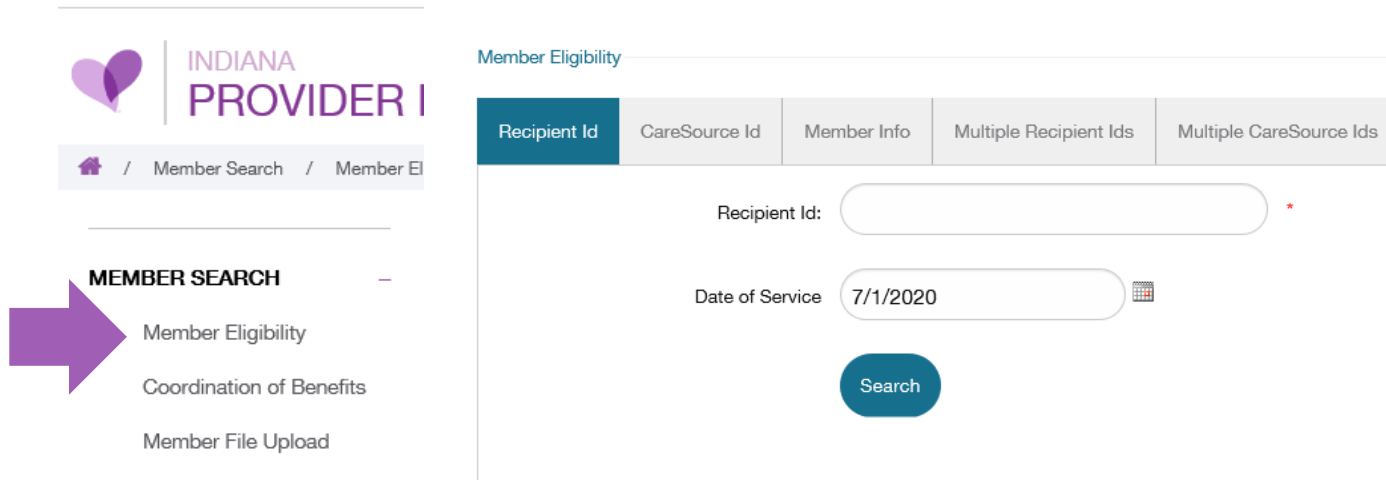
- ✓ Make it easier for you to work with us
- ✓ Partner with providers to help members make healthy choices
- ✓ Direct communication
- ✓ Timely and low-hassle medical reviews
- ✓ Accurate and efficient claims payment



Member Eligibility & Credentialing

Member Eligibility

Verification in the Provider Portal



The screenshot displays the Indiana Provider Portal interface. On the left, a sidebar contains the 'INDIANA PROVIDER I' logo and a navigation menu with 'MEMBER SEARCH' highlighted by a large purple arrow. The main content area is titled 'Member Eligibility' and features a tabbed interface with five tabs: 'Recipient Id' (selected), 'CareSource Id', 'Member Info', 'Multiple Recipient Ids', and 'Multiple CareSource Ids'. Below the tabs, there are input fields for 'Recipient Id' (with a red asterisk indicating a required field) and 'Date of Service' (set to 7/1/2020 with a calendar icon). A blue 'Search' button is positioned below these fields.

Upon logging into the Provider Portal, health partners will be able to view member eligibility:

- 24 months of history

- Member span information

- Multiple member look-up (up to 50)

Verify eligibility at every visit prior to rendering services.



Credentialing

- Credentialing with CareSource (including Contracting, Credentialing and Provider Loading) takes approximately 30-45 days
- The preferred method for submission is via the Provider Portal
- We now load all provider types individually in our system
 - See: <https://www.caresource.com/documents/in-med-p-279473-enhanced-credentialing-process-may-2021/>
- Reach out to your Health Partner Engagement Specialist with questions



Credentialing

Maintenance in the Provider Portal

- From the **Provider Tab**
- Click on **Provider Maintenance**
- Follow the steps

New Enhancement



PROVIDERS

Care Management Referral
Dental Provider Login
ER Referral
File Grievance
HIP Provider Cost Estimator
Pharmacy
Prior Authorization and Notifications
Provider Documents
Provider Maintenance
Quality Enhancer
Radiology Benefits Manager

Provider Maintenance

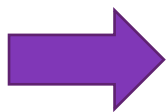
Demographic Change

Provider Add

Cultural/Linguistic/Accessibility Info

Status

Providers: Please Select



Credentialing

Submitting Requests via E-mail

- Submit a Hierarchy Form (HIE) and W9 to providermaintenance@caresource.com
- For large group updates providers can fill out page 1 of the HIE form and attach a roster (see below for pertinent information).

Provider		Deg.								
John Doe (SAMPLE)		MD								
Address			City/County		State		Zip			
123 Main St			Anytown		Indiana		99999			
Phone	Fax	NPI #	CAQH#		Medicaid/IHCP #		Medicare #			
317-555-1212	317-555-1213	1234567890	123456		1234567A		1234567			
Specialty		PCP? Y/N	HHW Capacity? (Min. 50)	HIP Capacity? (Min 50)	Cultural Competency (Y/N)		Competency Training Name			
Family Practice		Y	100	100	Yes		Cultural Comptency Training Name			
Age Restrictions? (18 yrs & older)		Race/Ethnicity	Gender Restrictions	Office Hours						
N		See below	N	Mon	Tues	Wed	Thur	Fri	Sat	Sun



Submitting Claims

INSTITUTIONAL & PROFESSIONAL



CareSource Claims

Billing Methods

CareSource accepts claims in a variety of formats:

- Electronic claims submitted through a clearinghouse
- Claims data submitted directly via our provider portal
- Postal mail

Claims

- For in-network providers, claims must be submitted within **90 calendar days** of the date of service or discharge.
- For out-of-network providers, claims must be submitted **within 180 calendar days** of the date of service or discharge.

Exceptions:

- ***Coordination of Benefits (COB):*** The claim and primary payer's explanation of payment (EOP) must be submitted to us within **90 calendar days** from the primary payer's EOP date. If a copy of the claim and EOP is not submitted within the required time frame, the claim will be denied for timely filing.



CareSource Claims

NPI Tax ID and Taxonomy

The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- UB-04 Claim – billing provider service location name, address and expanded ZIP Code + 4 in form field 1
- UB-04 Claim – 10 digit NPI for the billing provider in form field 56
- CMS 1500 Claim – billing provider taxonomy code is required in 33b
- CMS 1500 Claim – billing provider NPI is required in 33a

Please contact your Electronic Data Interchange (EDI) vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Rendering Provider Linkage

Health partners must be linked to all rendering locations in CoreMMIS. If not, claims will reject.





CareSource Claims

Box 33 of CMS-1500 Claim & form field 1 of the UB-04 **must** have the provider service location name, address and the ZIP code + 4 as listed on the IHCP provider enrollment profile.

PO Boxes **will not** be accepted in box 33. Please refer to IHCP Banner BR201820.



Billing Provider NPI – CMS-1500

On 837P professional claims, the billing provider NPI should be in the following location:

2010AA Loop – Billing Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

2310B Loop – Rendering Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering Provider NPI

The billing provider Tax Identification Number (TIN) must be submitted as the secondary provider identifier using a REF segment which is either the EIN for the organization or the SSN for individuals:

- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the Member ID number is entered:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Name



Billing Provider NPI – UB-04

On 837I Institutional claims, the billing provider NPI should be in the following location:

2010AA Loop – Billing Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

2310B Loop – Rendering Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering Provider NPI

The billing health partner TIN must be submitted as the secondary provider identifier using a REF segment which is either the EIN for the organization or the SSN for individuals:

- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the Member ID number should go on:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Name



Electronic Claims Submission

To submit claims electronically, health partners must work with an electronic claims clearinghouse. Please provide the clearinghouse with the CareSource payer ID number **INCS1**.

Availity

- As of June 1, 2020, our exclusive partner is Availity.
- This consolidation should not impact you if your clearinghouse can send transactions to Availity.
- For a list of EDI vendors who transmit EDI transactions to Availity EDI Gateway for CareSource transactions by using this link www.availity.com/caresourceedivendors.
- **If your current or desired clearinghouse is not on this list**, please contact them to confirm continuity of support for CareSource transactions.

Availity's Client Services can be reached at 1-800-Availity (1-800-282-4548).



Online Claim Submission

MEMBER SEARCH +

CLAIMS -

- Online Claim Submission
- Claim Information and Attachments
- Rejected Claims
- Payment History
- Recovery Request
- Disputes
- Appeals

MEMBER REPORTS +

USERS +

PROVIDERS -

- Care Management Referral
- Dental Provider Login

NEW FEATURE

CareSource has launched a new care management tool to review member assessments, care treatment plans, and more! Navigate to Member Eligibility and then click Assessments Taken or Care Treatment Plan. Look for the steps to guide you to the new tool.

Click the link below to learn more about this tool and to understand more about the launch date for each plan.

[LEARN MORE](#)

Electronic Remittance Advice (ERA) Issue with PLB and Claim Level Adjustments

On March 2, 2020, ECHO Health, Inc., delivered a correction to the 835 EDI files sending Claim Level Adjustments at the PLB – Provider (Document Level). All 835s going forward si

[Please review the network notification for more information.](#)

Provider Portal Survey

CareSource would love to hear about your experience on the provider portal today. The results from this survey will teach us insights on how we can improve the provider portal.

[Start the survey](#)

Under Claims, click on **Online Claim Submission**.

Online Claim Submission



Dashboard



Document Status



New Claim



Work Item



Reports



Help

CREATE HCFA

CREATE UB

CREATE DENTAL

UPLOAD CLAIM

DOCUMENT STATUS


	DCN	Submission Status to Payer	LOB/Claim Type	Incoming Mode	Total Charges
	To PCH Load Date	PatientDOB (MM/DD/YYYY)	InsuredDOB (MM/DD/YYYY)	From DOS	To DOS
	Insured LastName	Insured FirstName	Patient LastName	Patient FirstName	Reject Reason
<div>Search</div>					

Document Number	DCN	Submission Status to Payer	LOB/Claim Type	Incoming Mode	Total Charges	From PCH Load Date	PatientDOB (MM/DD/YYYY)	InsuredDOB (MM/DD/YYYY)	From DOS
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No data available in Workitem

Entries

Online Claim Submission

 HCFA Attachments		
<div>HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12</div>		CARESOURCE CARESOURCE PO BOX 8730 DAYTON OH 454018730
1. MEDICARE <input type="radio"/> MEDICAID <input type="radio"/> TRICARE <input type="radio"/> CHAMPVA <input type="radio"/> GROUP HEALTH PLAN <input type="radio"/> FECA BLK LUNG <input type="radio"/> OTHER <input type="radio"/> <small>(Medicare#) (Medicaid #) (Sponsor's SSN) (SSN or ID) (Medicare#) (SSN) (ID)</small>		1.a INSURED'S ID NUMBER <small>(For program in item 1)</small> INSURED ID
2. PATIENT'S NAME <small>(Last Name, First Name, Middle Initial)</small> LAST NAME FIRST NAME MIDDLE INITIAL SUFFIX		4. INSURED'S NAME <small>(Last Name, First Name, Middle Initial)</small> LAST NAME FIRST NAME MIDDLE INITIAL SUFFIX
5. PATIENT'S ADDRESS <small>(No., Street)</small> ADDRESS 1 ADDRESS 2 CITY STATE		7. INSURED'S ADDRESS <small>(No., Street)</small> <input type="checkbox"/> Same as Pat.Add ADDRESS1 ADDRESS2 CITY STATE
6. PATIENT RELATIONSHIP TO INSURED Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/>		8. RESERVED FOR NUCC USE
25. FEDERAL TAX ID NUMBER TAX ID SSN <input type="radio"/> EIN <input type="radio"/>	26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NO	27. ACCEPT ASSIGNMENT? Yes <input type="radio"/> No <input type="radio"/>
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small> LAST NAME FIRST NAME MIDDLE INITIAL SUFFIX CREDENTIAL MMDDCCYY Y	32. SERVICE FACILITY LOCATION INFORMATION <input type="checkbox"/> Ambulance FACILITY NAME SUFFIX FACILITY ADDRESS 1 FACILITY ADDRESS 2 FACILITY CITY FACILITY STATE FACILITY ZIP CODE EXT NPI FACILITY NPI Qualifier FACILITY QUAL PIN FACILITY PIN	28. TOTAL CHARGE \$ \$ 0.00 29. AMOUNT PAID \$ \$ 0.00 30. BALANCE DUE \$ \$ 0.00 33. BILLING PROVIDER INFO & PH # LAST NAME FIRST NAME MIDDLE NAME SUFFIX CREDENTIAL (0) PROVIDER NAME PROVIDER ADDRESS 1 PROVIDER ADDRESS 2 PROVIDER CITY PROVIDER STATE PROVIDER ZIP CODE I PROVIDER TELEPHONE NUMBER NPI QUAL PIN

Paper Claim Submission

UB-04 or CMS-1500 Paper Claims

- Submission must be done using the most current form version as designated by CMS.

CareSource does not accept handwritten claims, black and white claim forms or SuperBills.

- Detailed instructions for completing the UB-04 are available at <https://www.in.gov/medicaid/providers/469.htm>
- **Please note:** On paper UB-04 claims, the billing provider's NPI number should be placed in Box 56.
- Detailed instructions for completing the CMS-1500 are available at <https://www.in.gov/medicaid/providers/469.htm>

Please note: On paper CMS-1500 claims, the rendering NPI number should be placed in Box 24J and the billing provider NPI number in Box 33a and Group Taxonomy in 33b.

Paper Claim Submission

To ensure optimal claims processing timelines:

- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Font should be 10-14 point with printing in ***black ink***.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, TIN and taxonomy are required for all claim submissions.

Send all paper claim forms to CareSource at:

CareSource
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401

Provider Payment Process



Provider Payment Processing

Payment methods offered by ECHO Health, Inc.:

- Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)
- Virtual Card Payment
- Paper Check





Provider Payment Processing

Electronic Funds Transfer & Electronic Remittance Advice

EFT & ERA are the preferred methods of payments.

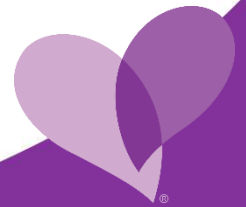
To register, please visit
<https://enrollments.echohealthinc.com/>

You will need:

- Your CareSource Provider ID
- Your bank routing number and bank account number

If already registered with ECHO, you will need:

- ECHO provider portal credentials or Tax Identification Number (TIN)
- An ECHO draft number and draft amount





Provider Payment Processing Virtual Card Payment

Standard credit card processing & transaction fees apply.

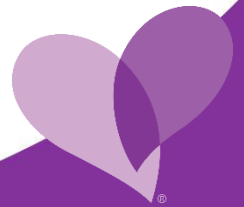
- Fees
- Additional fees are not charged
- A unique credit card number
- Processing





Provider Payment Processing Paper Check Payment

If your office would prefer to receive check payments, please call ECHO Support at 1-888-485-6233.





How to Resolve a Claim Concern



Claim Concerns

Claim Status

Claim status is updated daily on the CareSource Provider Portal. You can check claims that were submitted for the previous 36 months.

Additional information on the portal:

- Determine reason for payment or denial
- Check numbers and dates
- Procedure/diagnosis
- Claim payment date
- View and print remittance advice
- Check status of claim disputes or appeals





Claim Concerns Corrected Claims

- Providers have 60 calendar days from the date of EOP to submit a corrected claim
- UB-04 claims – Box 64
- CMS-1500 claims – resubmission code 7 and Box 22

Please note: If a corrected claim is submitted without this information, the claim will be processed as an original claim or rejected/denied as a duplicate.





Claim Concerns

Claim Disputes

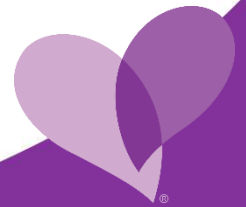
Definition: A provider's first response when disagreeing with the adjudication of a claim.

- Available for participating and non-participating providers

All disputes must be:

- Submitted in writing via the CareSource Provider Portal or on paper
- Submitted within 60 days after receipt of the EOP
- Completed **prior** to requesting an appeal

If CareSource fails to render a determination for the dispute within **30 days** after receipt, an appeal may be submitted.



Claim Concerns

Claim Disputes – Provider Portal

Disputes

File a claim payment dispute for a claim underpayment, a partially or fully denied claim (*please see below for a few exceptions*), or for an adverse claim payment decision.

A claim number is required to submit your claim dispute through the Portal. Any supporting documentation should also be attached.

The following should not be submitted as a Dispute:

If you are responding to a denied authorization that requires medical necessity review, please submit an [appeal](#).

If you are submitting a request due to overpayment, please submit a [claim recovery request](#).

If your claim was denied due to a missing consent form, please [upload the consent form](#).

If your hospital claim was denied due to missing medical records, please [upload the medical records](#).

Notice: CareSource is currently unable to receive dental appeals or disputes through the Portal. If you need to submit an appeal or dispute involving a dental claim, please mail your submission to:

Disputes

Submit Dispute

Check Status

Claim ID:

Find

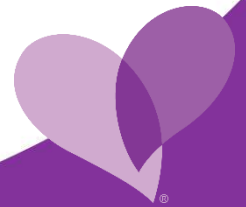


Claim Concerns

Claim Appeals

- Paper appeal form can be found at [CareSource.com](https://www.caresource.com)
- May only submit appeal **after** completing dispute process
- Must be submitted within **60 days** of the resolution of the dispute
- May submit via the CareSource Provider Portal, fax (937-531-2398), or by paper to:
Claim Appeals Department
P.O. Box 2008
Dayton, OH 45401-2008

****Timely filing appeals must include proof of original receipt of the appeal by fax or EDI for reconsideration****



Claim Concerns

Claim Appeals – Provider Portal

Post Service Appeals

Prior to filing an appeal you must submit a claim dispute to CareSource. You have the right to appeal once you have received your claim dispute decision or 30 calendar days have passed since CareSource received your dispute.

Notice: CareSource is currently unable to receive dental appeals or disputes through the provider portal. If you need to submit an appeal or dispute involving a dental claim, please mail your submission to:

CareSource
Attn: Grievance and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

You can also fax your submission to **937-531-2398**.

Post Service Appeals

Submit Appeal

Check Status

Claim ID:



Find





Top Denial Reasons

Top 8 Denial Reasons

Denial Reason	Resolution
Service not payable for provider	Provider needs to ensure their specialty is allowed to bill for this code & code is payable per IHCP fee schedules. File a dispute
Code does not have a contracted fee	CareSource recommends filing a dispute and reaching out to health partner engagement specialist, if code billed is valid & payable for provider's type.
Services disallowed by UM/ Units exceed UM authorization	Analyze claim form to confirm the prior authorization number is listed on the claim in box 23 on CMS 1500 and box 63 on UB04 & prior auth was obtained. File a dispute
Invalid diagnosis code/not a primary diagnosis code	Visit Indiana Medicaid website & code sets. File a dispute.



Top 8 Denial Reasons

Denial Reason	Resolution
Claim returned to provider for corrections/services not payable as billed	Check for correct coding: NCCI edits, modifiers, primary codes, etc. File a dispute
Incomplete, invalid rendering provider NPI	Evaluate box 33 on CMS 1500 to ensure appropriate information is entered. File a dispute
Procedure has an unbundled relationship	Verify appropriate NCCI edits, correct coding practices & CCI edits. File a dispute
NDC invalid or missing	Verify NDC billed is valid, on the claim, and appropriate units of measurement included. File a dispute



General Billing Codes

- [Emergency Department Autopay List](#)
- [Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG](#)
- [Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance](#)
- [Procedure Code Modifiers for Professional Claims](#)
- [Procedure Codes That Require Attachments](#)
- [Procedure Codes That Require NDCs](#)
- [Revenue Codes](#)
- [Revenue Codes with Special Procedure Code Linkages](#)
- [Service Codes That Require Electronic Visit Verification](#)

Service- and Provider-Specific Codes

- [Anesthesia Services Codes](#)
- [Chiropractic Services Codes](#)
- [Dental Services Codes](#)
- [Durable and Home Medical Equipment and Supplies Codes](#)
- [Family Planning Services Codes](#)
- [Hearing Services Codes](#)
- [Hospice Services Codes](#)
- [Injections, Vaccines, and Other Physician-Administered Drugs Codes](#)
- [Inpatient Hospital Services Codes](#)
- [Long-Term Care Codes](#)
- [Mental Health and Addiction Services Codes](#)
- [Obstetrical and Gynecological Services Codes](#)
- [Podiatry Services Codes](#)
- [Renal Dialysis Services Codes](#)
- [Surgical Services Codes](#)
- [Telehealth Services Codes](#)
- [Therapy Services Codes](#)
- [Transportation Services Codes](#)
- [Vision Services Codes](#)

Program- and Benefit-Specific Codes

- [Adult Mental Health Habilitation Codes](#)
- [Behavioral and Primary Healthcare Coordination Codes](#)
- [Family Planning Eligibility Program Codes](#)
- [Medicaid Rehabilitation Option Services Codes](#)
- [Medical Review Team Codes](#)
- [Presumptive Eligibility for Pregnant Women Codes](#)
- [Preventive Care Services Excluded from Copayment for HIP and PE Adult](#)

Code Sets

The Indiana Health Coverage Programs (IHCP) provides several code tables for provider reference, including:

- Necessary Codes
- Billable codes ("code sets")
- Codes related to specific coverage

<https://www.in.gov/medicaid/providers/business-transactions/billing-and-remittance/>





Important Updates & Reminders

Notification of Pregnancy [NOP]

Indiana Health Coverage Programs (IHCP) recognizes that timely identification of risk factors improves birth outcomes.

The Notification of Pregnancy (NOP) form pinpoints risk factors in the earliest stages of pregnancy for women enrolled in HIP and HHW.

A qualified provider is eligible for a \$60 reimbursement for one NOP per pregnancy

- Submit claim 99354-TH if you completed the NOP
- The NOP must be submitted via the Provider Portal no more than five calendar days from the date of the office visit on which the NOP is based
- The member's pregnancy must be less than 30 weeks' gestation at the time of the office visit on which the NOP is based.
- CareSource will pay a \$10 enhancement to this code if billed within the 1st trimester





Enhanced Credentialing

CareSource now loads all provider specialties into our directory, including ancillary provider types:

- Radiology
- Anesthesiology
- Pathology
- Hospitalist services
- Emergency medicine
- PT/OT/ST



Member Billing

Not permitted:

- Balance billing a member for a Medicaid-covered service
- Billing a member in emergent situations

To charge a member for non-covered services, health partners must disclose in writing:

- Service to be rendered is not covered by Medicaid.
- Whether procedures or treatments that **are** covered by Medicaid are available in lieu of non-covered service.
- The health partner must offer, on a disclosure form, the member's willingness to accept the financial responsibility of the non-covered service, the amount to be charged for the non covered service and the specific date the service is to be performed.
- **Documentation must be signed by member prior to rendering the specific non-covered service.**

Note: Medicaid covered services **cannot** be billed to the member.





Quarterly Friday Forums

- Revenue cycle, contracting, credentialing, clinical operations, quality, or administrative staff are welcome to attend
 - Brief presentation covering updates
 - Live Q&A after
-
- December 17th 2 pm – 4 pm
 - Save the Date will be published on our Updates & Announcements Page



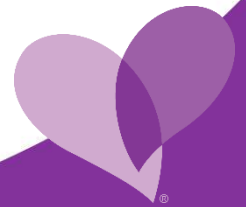


Visit the **Updates and Announcements** page located on our website for frequent network notifications.

Updates & Announcements

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements



How to Reach Us

Provider Services	1-844-607-2831
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)
Member Services	1-844-607-2829
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)



CareSource Health Partner Engagement Representatives

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Regional Medical Center, Beacon

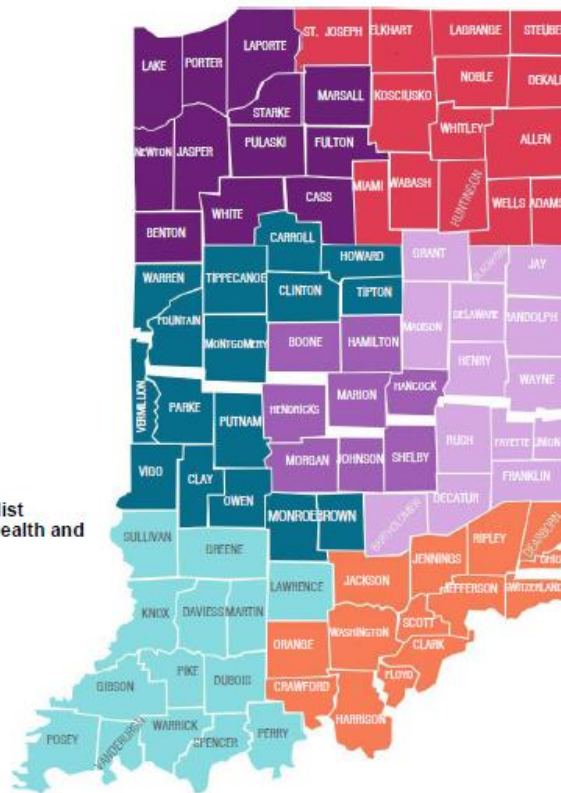
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Baptist Health Floyd



IN-P-0190j

Date Issued: 08/30/2021

OMPP Approved: 07/30/2020

A photograph of three children hugging outdoors. A young boy with light hair is in the background, smiling. In the foreground, a young girl with dark skin and curly hair is smiling, and another girl with light skin and brown hair is hugging her from behind. They are in a sunny outdoor setting with greenery and a house in the background.

Thank you!

IN-MED-P-882427 Issued Date: 9/17/21

OMPP Approved: 9/17/21


CareSource
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